VERSANT LIFE INSURANCE
PO DRAWER 83480
BATON ROUGE, LA 70884-3480

PROOF OF DEATH CREDITOR INSURANCE CLAIM FORM

INSTRUCTIONS FOR FILING A CLAIM FOR DEATH BENEFITS

THIS CLAIM FORM IS USED FOR FILING A DEATH CLAIM WITH VERSANT LIFE INSURANCE. THE CLAIM FORM MUST BE COMPLETED FULLY AND CORRECTLY BY THE SECONDARY BENEFICIARY, SURVIVING SPOUSE OR NEAREST RELATIVE OF THE DECEASED. ANSWER ALL QUESTIONS IN THEIR ENTIRETY. YOU ARE RESPONSIBLE FOR THE COMPLETION OF THE CLAIM FORM AND FORWARDING THE NECESSARY INFORMATION TO OUR OFFICE. IF THE CLAIM SUBMITTED TO US IS INCOMPLETE, THIS WILL RESULT IN A DELAY IN PROCESSING THE CLAIM FOR BENEFITS.

THE CLAIM FORM AND AUTHORIZATION(S) SHOULD BE COMPLETED IN THE DESIGNATED AREAS AND SUBMITTED (MAILED) TO OUR OFFICE WITH A CERTIFIED COPY OF THE DEATH CERTIFICATE, AND ANY ATTACHMENTS OR CORRESPONDENCE. FAX COPIES OF CLAIM FORMS AND/OR DEATH CERTIFICATES WILL BE ACCEPTED AS NOTICE OF YOUR CLAIM. HOWEVER, THE ORIGINAL CLAIM FORM, CERTIFIED COPY OF THE DEATH CERTIFICATE, AUTHORIZATIONS AND ANY ATTACHMENTS MUST BE MAILED TO OUR OFFICE. COPIES OR FAXES OF THE DEATH CERTIFICATES WILL BE NOT BE ACCEPTED AS PROOF OF YOUR CLAIM

THERE MAY BE TWO (2) AUTHORIZATIONS FOR THE RELEASE OF INFORMATION. ONE IS FOR THE CREDITOR BENEFICIARY (LIENHOLDER). THIS AUTHORIZATION IS NEED IN ORDER FOR VERSANT LIFE INSURANCE TO SECURE THE LOAN INFORMATION FROM THE LIENHOLDER IN ORDER TO SETTLE A CLAIM. DUE TO FEDERAL PRIVACY REQUIREMENTS, THE LIENHOLDER NEEDS THIS AUTHORIZATION TO RELEASE LOAN INFORMATION AND MOST IMPORTANT, THE PAYOFF AMOUNT OF THE LOAN. WE DO RECOMMEND THAT YOU ADVISE THE CREDITOR BENEFICIARY AS SOON AS POSSIBLE OF THE FILING OF THIS CLAIM FOR DEATH BENEFITS.

IF THE POLICY FOR INSURANCE IS LESS THAN TWO YEARS OLD OR THE CAUSE OF DEATH IS NOT AN ACCIDENT, THE SURVIVING SPOUSE OR NEAREST RELATIVE TO THE DECEASED MUST COMPLETE THE MEDICAL HISTORY QUESTIONNAIRE ON THE BACK OF THE CLAIM FORM AND COMPLETE THE DESIGNATED AREAS ON THE SECOND AUTHORIZATION. THIS HIPPA COMPLIANT AUTHORIZATION IS NECESSARY IN THE EVENT WE NEED TO REQUEST COPIES OF MEDICAL RECORDS.

SHOULD YOU HAVE ANY QUESTIONS REGARDING THE COMPLETION OF THE CLAIM FORM, PLEASE DO NOT HESITATE TO CONTACT OUR OFFICE AT THE TELEPHONE NUMBERS GIVEN BELOW.

Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for purpose of misleading, information concerning any fact, material thereto, commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and civil penalties.

VERDCF - POD - 10/08

VERSANT LIFE INSURANCE
PO DRAWER 83480
BATON ROUGE, LA 70884-3480

PROOF OF DEATH CREDITOR INSURANCE CLAIM FORM
A certified copy of the Death Certificate should be attached to this form.

INSURANCE AND LOAN ACCOUNT INFORMATION (THIS INFORMATION IS NEEDED TO IDENTIFY THE INSURANCE COVERAGE AND THE PROPER CREDITOR BENEFICIARY).

Name of Deceased :_____

Date of Birth: _____ Social Security #: _____

Life Certificate(s) #: _____ Writing Dealership/Bank**:** _____

Creditor Company (Creditor Beneficiary):_____

Mailing Address : _____

Phone #: (____) _____ Loan Account #: _____

YOU MAY ATTACH A COPY OF THE PAYMENT COUPON OR BILLING STATEMENT SHOWING THE LOAN ACCOUNT NUMBER AND THE ADDRESS OF THE CREDITOR BENEFICIARY. IF THE LOAN IS PAID OFF, PLEASE FORWARD WRITTEN PROOF SHOWING THAT THE LOAN HAS BEEN PAID OUT.

SECONDARY BENEFICIARY STATEMENT (To be completed by the named Secondary Beneficiary on the policy or certificate, Surviving Spouse or Nearest Next of Kin).

_____ _____
Secondary Beneficary/Surviving Spouse / Nearest Relative Relationship to Deceased

_____ _____
Address (include Apt. or Lot #) Date

_____ (_____) _____
City, State, Zip Code Telephone Number (Include Area Code)

If "Estate" is indicated as the Secondary Beneficiary, is there an Estate of the deceased? No ____ Yes ____

If yes, Name of Admisistrator/Administratrix of the Estate and Address (attach letters of administration):

_____

I hereby certify that the answers given above are full, true and complete.

_____ _____
Date Signature Secondary Beneficiary/Surviving Spouse / Nearest Next of Kin

NOTE: IF THE CERTIFICATE FOR INSURANCE IS LESS THAN TWO YEARS OLD OR THE CAUSE OF DEATH IS NOT AN ACCIDENT, THE MEDICAL HISTORY QUESTIONNAIRE AND AUTHORIZATION ON THIS CLAIM FORM MUST BE COMPLETED AND SIGNED.

LOCAL (225) 769-9923 TOLL FREE NUMBER (800) 622-6838 FAX (225) 769-4477

VERSANT LIFE INSURANCE
PO DRAWER 83480
BATON ROUGE, LA 70884-3480

AUTHORIZATION FOR RELEASE OF INFORMATION FROM THE CREDITOR BENEFICIARY (LIENHOLDER) ON THE LOAN ACCOUNT OF DECEASED INSURED DEBTOR

I hereby authorize:

_____,
Creditor Company (Creditor Beneficiary)

to release and furnish VERSANT LIFE INSURANCE of Baton Rouge, Louisiana, or its representatives, any and all protected loan account information concerning the account of:

_____, _____,
(Name of the Deceased Insured Debtor) **(Loan Account #)**

_____.
(Social Security #)

This information disclosed is for the purpose of an evaluation or settlement of a claim for insurance. I understand that once information is disclosed pursuant to this Authorization, the released information may no longer be protected by federal privacy regulations and may be subject to re-disclosure by Versant Life Insurance. I have the right to receive a copy of this Authorization after I sign it.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED LOAN INFORMATION AS STATED. A COPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL.

_____ _____
SPOUSE/NEAREST RELATIVE OF DECEASED (SIGNATURE) **DATE**

_____
RELATIONSHIP TO DECEASED

VERDCF - POD - 10/08

VERSANT LIFE INSURANCE
PO DRAWER 83480
BATON ROUGE, LA 70884-3480

IN THE EVENT THE CERTIFICATE OF INSURANCE IS LESS THAN TWO YEARS OLD, OR THE DEATH IS A RESULT OF AN ACCIDENT, THE SURVIVING SPOUSE OR NEAREST RELATIVE TO THE DECEASED MUST COMPLETE THE MEDICAL HISTORY QUESTIONNAIRE BELOW AND SIGN THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

MEDICAL HISTORY QUESTIONNAIRE

NAME OF DECEASED INSURED DEBTOR _____

NAME, ADDRESS & TELEPHONE NUMBER OF DECEASED INSUREDS FAMILY PHYSICIAN

_____

_____

NAME, ADDRESS & TELEPHONE NUMBER OF ANY PHYSICIANS WHO MAY HAVE TREATED THE DECEASED INSURED WITHIN THE PAST THREE (3) YEARS

_____

_____

_____

NAME, ADDRESS OF HOSPITALS THE DECEASED INSURED WAS ADMITTED AND/OR CONFINED

_____

_____

_____

GIVE A BRIEF SUMMARY OF THE DECEASED INSUREDS PAST MEDICAL HISTORY (Doctor Name, Hospital Name, Diagnosis, Dates of Treatments, Medications or Prescriptions, etc.)

_____

_____

_____

_____ _____
SPOUSE/ NEAREST RELATIVE OF DECEASED **RELATIONSHIP TO DECEASED**

_____ _____
ADDRESS **DATE**

_____ (_____)_____
CITY, STATE, ZIP CODE **TELEPHONE**

VERSANT LIFE INSURANCE

CLAIMS OFFICE: PO BOX 84410

BATON ROUGE, LA 70884-441

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ **Date of Birth:** _____

Address: _____

Social Security #: _____ **Date of Death:** _____

AUTHORITY TO RELEASE PROTECTED HEALTH INFORMATION

I hereby authorize _____ **(covered entity/ provider) to release Versant Life Insurance the Protected Health Information (PHI) identified in this authorization form from the medical records of the patient listed above.**

INFORMATION TO BE RELEASED-COVERING THE PERIODS OF HEALTH CARE

Disclose the following PHI for treatment date starting at _____ to ending date _____.

X Other: Entire Medical Record excluding Itemized Billing Statement

THE ABOVE INFORMATION IS DISCLOSED FOR THE PURPOSE OF:
Insurance – Evaluation of a claim for insurance benefits

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE OR EVENT:
Unless revoked, this authorization will expire on the following event:
EVENT/EXPIRATION DATE: One (1) year from the date of this Authorization

DRUG AND /OR ALCOHOL ABUSE, AND/OR HIV/AIDS RELEASE
I understand if the medical records contain information in reference to drug and/or alcohol abuse, Psychiatric Care, Communicable disease(s), Hepatitis or HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment, I consent and agree to the release (without restriction) of this information.

I UNDERSTAND THAT:
1. I may refuse to sign this Authorization and it is strictly voluntary.
2. I understand that my treatment, payment, enrollment or eligibility for benefits provided by or through a qualified healthcare provider may not be conditioned on signing this authorization. However, Versant Life Insurance may condition payment of a claim or the eligibility of benefits upon my signing this Authorization, if the disclosure of information is necessary to determine the validity of a claim or its payment.
3. I have the right to revoke this Authorization at any time. Revocation must be in writing, to the covered entity/ provider authorized to release the Protected Health Information (PHI) or Versant Life Insurance. I understand that the revocation will not apply to information that has already been released to this Authorization.
4. I understand that once information is disclosed pursuant to this Authorization, the released information may no longer be protected by federal privacy regulations and may be subject to redisclosure by Versant Life Insurance.
5. I have the right to receive a copy of this Authorization after I sign it.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION AS STATED. A COPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL.

Signature of Patient's Representative: _____ **Phone #:** _____

Representative's Relationship to Patient: _____ **Date:** _____

TOLL FREE NUMBER (800) 622-6838 FAX (225) 769-4477